Family physicians' attitudes toward advance directives

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Objective: To examine the attitudes toward, the experience with and the knowledge of advance directives of family physicians in Ontario.
Design: Cross-sectional survey.
Participants: A questionnaire was mailed to 1000 family physicians, representing a random sample of one-third of the active members of the Ontario College of Family Physicians; 643 (64%) responded.
Results: In all, 86% of the physicians favoured the use of advance directives, but only 19% had ever discussed them with more than 10 patients. Most of the physicians agreed with statements supporting the use of advance directives and disagreed with statements opposing their use. Of the respondents 80% reported that they had never used a directive in managing an incompetent patient. Of the physicians who responded that they had such experience, over half said that they had not always followed the directions contained in the directive. The proportions of physicians who responded that certain patient groups should be offered the opportunity to complete an advance directive were 96% for terminally ill patients, 95% for chronically ill patients, 85% for people with human immunodeficiency virus infection, 77% for people over 65 years of age, 43% for all adults, 40% for people admitted to hospital on an elective basis and 33% for people admitted on an emergency basis. The proportions of physicians who felt that the following strategies would encourage them to offer advance directives to their patients were 92% for public education, 90% for professional education, 89% for legislation protecting physicians against liability when following a directive, 80% for legislation supporting the use of directives, 79% for hospital policy supporting the use of directives, 73% for reimbursement for time spent discussing directives with patients and 64% for hospital policy requiring that all patients be routinely offered the opportunity to complete a directive at the time of admission.
Conclusions: Family physicians favour advance directives but use them infrequently. Most physicians support offering them to terminally or chronically ill patients but not to all patients at the time of admission to hospital. Although governments emphasize legislation, most physicians believe that public and professional education programs would be at least as likely as legislation to encourage them to offer advance directives to their patients.

Objectif : Examiner l'attitude, l'expérience et les connaissances des médecins de famille ontariens par rapport aux directives préalables.
Conception : Enquête transversale.
Participants : On a envoyé un questionnaire par la poste à 1 000 médecins de famille, ce qui représente un échantillon aléatoire d'un tiers des membres en règle du Collège des médecins de famille de l'Ontario; 643 médecins (64 %) ont répondu.
Résultats : En tout, 86 % des médecins favorisaient l'utilisation des directives préalables, mais seulement 19 % en avaient déjà discuté avec plus de 10 patients. La plupart des médecins étaient d'accord avec les énoncés appuyant l'utilisation des directives

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The views expressed herein are those of the authors and do not necessarily reflect the views of the sponsoring agencies.

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préalables, et ils s'opposaient aux énoncés à l'encontre de leur utilisation. Quatre-vingts pour cent des répondants ont signalé qu'ils n'avaient jamais eu recours à une directive pour traiter un patient incapable. Parmi les médecins ayant dit avoir eu une telle expérience, plus de la moitié ont affirmé ne pas toujours avoir suivi les instructions de la directive. Les proportions de médecins qui ont répondu qu'on devrait donner l'occasion à certains groupes de patients de remplir une directive préalable étaient de 96 % pour les patients en phase terminale, de 95 % pour les malades chroniques, de 85 % pour les personnes atteintes d'infection à virus de l'immunodéficience humaine, de 77 % pour les personnes de plus de 65 ans, de 43 % pour tous les adultes, de 40 % pour les personnes admises à l'hôpital à titre facultatif et de 33 % pour les personnes admises dans un situation d'urgence. Les proportions de médecins qui estimaient que les stratégies suivantes les encourageraient à offrir des directives préalables à leurs patients étaient de 92 % pour la sensibilisation du public, de 90 % pour la formation des professionnels, de 89 % pour une loi protégeant les médecins contre les poursuites lorsqu'ils suivent une directive, de 80 % pour une loi appuyant l'utilisation des directives, de 79 % pour une politique d'hôpital appuyant l'utilisation des directives, de 73 % pour le remboursement des heures consacrées à discuter des directives avec les patients et de 64 % pour une politique d'hôpital exigeant qu'on donne systématiquement à tous les patients la possibilité de remplir une directive à l'admission.

Conclusions : Les médecins de famille sont pour les directives préalables, mais ils les utilisent rarement. La plupart des médecins veulent les offrir aux patients en phase terminale ou aux patients chroniques mais non pas à tous les patients au moment de l'admission à l'hôpital. Bien que les gouvernements mettent l'accent sur la législation, la plupart des médecins croient que des programmes d'information publics et professionnels auraient autant de chances que les lois de les encourager à offrir des directives préalables à leurs patients.

Advance directives are documents written by competent people to influence their care in the event that they lose the capacity to participate in treatment decisions.[1,2] There are two types: instruction directives and proxy directives. Instruction directives (also called living wills) enable patients to express their preferences with regard to specific life-sustaining treatments. Proxy directives (also called durable powers of attorney for health care) enable patients to appoint a specific person to make health care decisions on their behalf. Advance directives may contain instruction and proxy components.

In the United States 49 states have enacted legislation on advance directives. Moreover, the patient self-determination provisions of the 1990 US Omnibus Budget Reconciliation Act require hospitals receiving Medicare or Medicaid reimbursement to inform all patients at the time of admission of their right to complete an advance directive.[3] In Canada Nova Scotia and Quebec have legislation supporting proxy directives.[4,5] No province currently has legislation on instruction directives.

Fifteen percent of people in the United States have completed an advance directive.[6] We are unaware of comparable published data for Canada. Nevertheless, the prevalence of directives in Canada will likely increase in response to recent legislative initiatives.[7,8] As more people become aware of advance directives physicians will be called upon more frequently to offer, discuss and act upon them. In Canada these duties frequently fall on family physicians, who as primary care providers are ideally suited to offer and assist patients in completing advance directives.

Six previous studies have examined physicians' attitudes toward advance directives.[9-14] Two, published in the late 1970s, assessed the impact of the California Natural Death Act. Klutch[9] reported that physicians were evenly divided on whether the act had served any useful purpose and that they had little experience using advance directives in clinical situations. Redleaf, Schmitt and Thompson[10] found that although most physicians knew of the act they had little appreciation of its clinical implications; moreover, although 55% of physicians had discussed advance directives with their patients, less than 15% had raised the subject themselves.

Zinberg[11] reported that 85% of selected physicians in Vermont and California supported the concept of advance directives. Although 65% had discussed them with their patients, only 14% of the physicians said that they had initiated the discussion. The physicians had limited knowledge of state laws pertaining to advance directives and felt that the laws had little effect on their clinical practice. Although 42% of the physicians were found to have treated patients with directives, the directive had changed the treatment plan in only two cases. Physicians said that they were primarily influenced by the family's wishes when making treatment decisions.

Surveys of physicians in Wisconsin[12] and Arkansas[13] revealed that 90% and 80% of the respondents

respectively supported the use of advance directives. The Wisconsin study found that there was concern regarding certain provisions of the state's legislation, such as the restrictive definition of "terminally ill." Only 36% of the Wisconsin physicians thought that the law was an effective means of allowing the withdrawal or withholding of life-sustaining treatment, and only 18% thought that the law had made a difference in their clinical practice. The Arkansas study found that 56% of physicians had clinical experience with advance directives and that this experience was generally positive.

Most recently a survey of North Carolina physicians showed that 97% of the respondents knew of living wills, 14% had executed one for themselves, and 81% were willing to keep a copy of their patients' living wills in their office records.[14]

The purpose of our study was to examine the attitudes toward, experience with and knowledge about advance directives of Ontario family physicians. Our study differed from previous research in four respects. First, we examined physicians' attitudes toward previously unexplored questions of practical importance such as what type of advance directive physicians prefer, who should be offered directives, and what strategies would encourage physicians to offer directives to their patients. Second, we examined physicians' attitudes in a jurisdiction where there is no legislation regarding advance directives. Third, we focused exclusively on family physicians. Finally, this is the first comprehensive collection of data on physicians' attitudes toward advance directives in Canada. (A previous study was reported on the impact of directives on physicians' decisions.[15])

Methods

We developed a 50-item questionnaire to determine the attitudes of Ontario family physicians toward advance directives, their experience in discussing directives with competent patients, their experience in using them in clinical situations, their knowledge of the legal standing of advance directives in Ontario, what type of directive they prefer, who should be offered the opportunity to complete a directive and what strategies might encourage physicians to offer advance directives. The questionnaire also requested information about the physician's age, sex, year of graduation from medical school, country where the medical degree was obtained and practice pattern (population of community, type of practice and source of remuneration). The questionnaire was pilot-tested on 10 members of the University of Toronto Department of Family and Community Medicine. It is available from the authors upon request.

The questionnaire was mailed on Nov. 1, 1990, to 1000 family physicians, a random sample of one-third of the active members of the Ontario College of Family Physicians. The questionnaire was accompanied by a letter defining the terms advance directive, instruction directive, proxy directive and competent. One week later a reminder was sent, and 3 weeks later the questionnaire and an updated cover letter were mailed to those who had not responded.

Data were analysed with the use of the SAS computer program.[16] In univariate analyses the data were presented as the proportion of respondents giving each response to a given question. In bivariate analyses we used analysis of variance and χ^2 tests as appropriate.

This study was approved by the Ethics Committee of the Wellesley Hospital Research Institute, Toronto, Ont.

Results

In all, 643 (64%) of the 1000 physicians completed the questionnaire. Of those that did not do so 111 (11%) returned a response card declining participation in the study; 18 (2%) of the questionnaires were returned undelivered. Because not all respondents answered each question the numbers did not always add up to 643; also, because of rounding error proportions did not always add up to 100%.

Respondent characteristics

Of the respondents whose sex was indicated 212 were women (33%) and 426 men (67%). The age varied from 25 to 63 (median 38) years. The median year of graduation from medical school was 1979 (extremes 1950 and 1988). Of the respondents 578 (90%) had received their medical degree in Canada, 28 (4%) in the United Kingdom, 6 (1%) in Ireland, 5 (1%) in South Africa, 4 (1%) in India, 1 (0.2%) in the United States and 18 (3%) in some other country.

In all, 345 (54%) of the physicians practised in a community of more than 100 000 people, 83 (13%) in one of 50 001 to 100 000 people, 100 (16%) in one of 10 001 to 50 000 people, and 111 (17%) in one of 10 000 or less.

Of the physicians who specified their type of practice 75 (12%) had a group practice affiliated with a teaching hospital, 251 (39%) had a group practice not affiliated with a teaching hospital, 34 (5%) had a solo practice affiliated with a teaching hospital, and 186 (29%) had a solo practice not affiliated with a teaching hospital. Ninety-five physicians (15%) classified themselves in other categories, including practice in multiple settings and full-time work in an emergency department.

The major source of remuneration was indicated as follows: fee for service (reported by 542 physicians [85%]), salary (by 55 [9%]), capitation (by 33 [5%]) and other (by 11 [2%]).

Attitudes toward advance directives

The attitudes of the physicians toward advance directives are shown in Table 1. Most of the physicians favoured the use of directives (86% strongly agreed or agreed with their use), agreed with statements supporting the use of such directives and disagreed with statements opposing their use. Graduates of Canadian medical schools were more likely than foreign graduates to favour the use of directives ($p < 0.001$). Support for directives was not associated with any other respondent characteristic or with experience in treating patients who had a directive.

Experience discussing directives with patients

Of the respondents who answered this question 230 (38%) said that they had never discussed advance directives with their patients, 269 (44%) had discussed them with 10 patients or fewer, and 114 (19%) had discussed them with more than 10 patients. The median number of patient discussions was three per physician.

Of those physicians who had discussed advance

Table 1: Attitudes of family physicians in Ontario regarding considerations supporting and opposing the use of advance directives

Consideration	Response; % of physicians		
	Agree or strongly agree	Undecided	Disagree or strongly disagree
Supporting the use of advance directives			
It is important for patients to be able to influence their medical treatment should they lose competence (n = 640)	90	5	5
I favour the use of advance directives (n = 639)	86	11	3
I worry less about the legal consequences of limiting treatment if I am following an advance directive (n = 635)	75	15	10
Advance directives reduce family discord over decisions to withhold treatment (n = 639)	72	21	8
Patients worry less about unwanted treatment after completing an advance directive (n = 634)	72	24	4
Widespread use of advance directives could help contain unnecessary medical expenditures (n = 638)	65	25	11
Opposing the use of advance directives			
Patients frequently change their minds about life-sustaining treatment after becoming terminally ill (n = 637)	19	37	44
I am concerned that advance directives will lead to acceptance of active euthanasia (n = 637)	15	14	71
Advance directives represent unwarranted extension of the law into the practice of medicine (n = 638)	7	15	79
Prolonging life is more important than honouring a patient's request to forgo life-sustaining treatment (n = 638)	3	3	94

directives with one or more patients 316 (84%) said that less than 1% of their patients currently have a directive, 57 (15%) said that 1% to 10% of their patients have one, and 5 (1%) said that more than 10% of their patients have one.

With regard to who usually initiated the discussion 247 (66%) of the respondents said that their patients did so, 48 (13%) said that they did so, and 82 (22%) said that they and their patients raised the topic about equally. Five (1%) of the physicians said that someone other than themselves or the patient (most often a member of the patient's family) usually initiated the discussion.

Of the physicians who indicated the status of their patients when they completed an advance directive 179 (48%) said that their patients were usually healthy, 99 (26%) said that they were usually chronically ill, and 52 (14%) reported that they were usually terminally ill. Thirty respondents (8%) stated that there was no predominant state of health or disease of their patients at the time of completing a directive. The remaining 15 respondents (4%) said that the patients were elderly, a serious illness had recently been diagnosed, the patients had survived a serious acute illness, or they had been bereaved.

Most (306 [84%]) of the physicians reported that their patients usually completed an instruction directive, 50 (14%) said that they used instruction and proxy directives about equally, and 10 (3%) said that they usually completed a proxy directive.

The following physician factors were associated with greater experience discussing advance directives: higher age ($p < 0.001$), earlier graduation from medical school ($p < 0.001$) and solo practice affiliated with a teaching hospital ($p < 0.05$).

Experience with advance directives in clinical situations

Most (505 [80%]) of the physicians had never had experience using an advance directive in a clinical situation involving an incompetent patient, 116 (18%) had referred to an advance directive with 1 to 10 patients, and 12 (2%) had done so with more than 10 patients. The median number was 0 patients per physician.

Of the 128 physicians who had any experience using advance directives in a clinical situation 126 indicated how frequently the directives were followed: 56 (44%) always followed them, 54 (43%) followed them 75% to 99% of the time, and 14 (11%) followed them less than 75% of the time; 2 (2%) said that they never followed them.

Of the 70 physicians who said that they had refused to follow directions in an advance directive 52 gave a reason: the family disagreed with the directive (given by 14 [27%] of the physicians), the wording of the directive was not felt to be appropriate for the clinical situation encountered (11 [21%]), the patient was not terminally ill (10 [19%]), the preferences expressed in the directive were not really understood by the patient and would be different if the patient were aware of the situation (8 [15%]), and the preferences expressed were out of date (6 [12%]); 3 (6%) of the physicians gave some other reason.

Knowledge of the legal standing of advance directives

In Ontario at the time of this study there was case law supporting instruction directives, no case law supporting proxy directives and no legislation supporting either of the two types. Eighty-nine (14%) of the respondents knew that there was case law supporting instruction directives, 44 (7%) knew that there was no case law supporting proxy directives, 161 (25%) knew that there was no legislation supporting instruction directives, and 104 (16%) knew that there was no legislation supporting proxy directives. The number of physicians who stated that they did not know the answer to each of the four questions varied from 460 (72%) to 527 (83%). Two physicians (0.3%) answered all four questions correctly.

What type of directive is preferred?

In all, 250 (40%) of the physicians preferred that their patients use a mixed directive (comprising both instruction and proxy components), 177 (28%) preferred an instruction directive, 91 (14%) said that either type was acceptable, 7 (1%) preferred a proxy directive, and 107 (17%) were unsure.

Of the respondents 174 (28%) said that the wording of the instruction directive was "about right," 114 (18%) said that it was usually "too vague," 33 (5%) said that it was usually "too specific," and 306 (49%) were unsure.

Who should be offered an advance directive?

We asked the physicians whether they thought people in nine identifiable groups should be offered the opportunity to complete an advance directive (Table 2). The physicians favoured offering a directive more often to terminally and chronically ill patients than to all patients admitted to hospital, particularly those admitted through the emergency department. Physicians volunteered that other patient groups should be offered the opportunity to complete an advance directive: people over 75 years of age, people with recent stroke or progressive neurologic disease and children with a life-threatening illness. Two physicians volunteered that patients

with a history of attempted suicide should *not* be offered the opportunity.

Female physicians were more likely than male physicians to favour offering the opportunity to people with human immunodeficiency virus infection ($p = 0.03$), people who participate in high-risk activities such as car racing ($p = 0.04$), all adults ($p = 0.009$) and people admitted to hospital through the emergency department ($p < 0.001$).

What strategies will encourage family physicians to offer advance directives?

We asked physicians whether they thought each of seven potential strategies would encourage, discourage or have no effect on whether they would offer advance directives to their patients (Table 3). Public and professional education programs were the most favoured strategies, whereas hospital policy requiring that all patients be routinely offered the opportunity to complete a directive at the time of admission was the least favoured strategy.

Female physicians were more likely than their male counterparts to support a strategy requiring the offering of a directive to patients at the time of admission to hospital ($p < 0.001$).

Discussion

Our study had five principal limitations. First, active members of the Ontario College of Family Physicians maintain annual continuing education standards; thus, their attitudes and experiences may differ from those of general practitioners who are not members of the college. Second, the respondents were self-selected, and their attitudes and experiences may have differed from those of nonrespondents. Third, the responses may have been subject to recall bias. Fourth, the respondents may have made inaccurate predictions. Finally, the physicians may have provided responses on these sensitive issues that they felt conformed to social norms (social desirability bias).

Despite these limitations our study provides information that should be of interest to physicians and of practical use to those developing legislation, policies or educational programs dealing with advance directives.

Most of the family physicians in our study favoured the use of advance directives, agreed with statements supporting such use and disagreed with statements opposing such use. The physicians' attitudes were similar to those of physicians in US jurisdictions with legislation on advance directives. For example, our finding that 86% of the physicians supported the use of advance directives is comparable to data from Vermont and California (85%),[11] Wisconsin (90%)[12] and Arkansas (80%).[13]

Despite their positive attitude toward advance directives the family physicians in our study had relatively little clinical experience with them. They discussed them with a median of only three patients.

Table 2: Attitudes of family physicians regarding which people should be offered the opportunity to complete an advance directive

Group characteristic	Response; % of physicians		
	Yes	No	Not sure
Terminally ill (likely to die within 6 mo) (n = 631)	96	1	3
Chronically ill (e.g., have end-stage renal disease necessitating dialysis) (n = 631)	95	2	3
Seropositive for human immunodeficiency virus (n = 630)	86	4	10
Over age 65 yr (n = 627)	77	8	15
Participate in high-risk activities (e.g., car racing) (n = 629)	64	17	18
All adults (n = 631)	43	30	27
Hold a valid driver's licence (n = 627)	42	32	26
Admitted to hospital on an elective basis (n = 630)	40	37	23
Admitted to hospital on an emergency basis (n = 630)	33	38	30

This may be due in part to a lack of knowledge regarding the legal standing of directives in Ontario. Moreover, in accord with previous studies[10,11] we found that the physicians were more likely to wait for their patients to raise the topic than to raise it themselves. Recent studies have shown that patients wish to discuss advance directives with their physicians.[17-20] We recommend educational programs for physicians that explore and help to overcome their reluctance to raise the topic with their patients.

Given the lack of experience discussing advance directives it is not surprising that the physicians in our study also had little experience following directives when treating incompetent patients. However, of the physicians who had used a directive in a clinical setting 56% said that they had not always followed the directions in the directive. This finding is in accord with the results of a recent cohort study involving nursing-home patients.[21] Reasons for noncompliance with an advance directive included family disagreement, inappropriate or unclear wording of the directive, an illness that was not terminal, the likelihood that the patient's preference expressed in the directive would change if he or she were aware of the clinical situation, and the obsolescence of the directive. Some of these reasons seem to be appropriate. It may be that the appropriate rate of compliance with patients' directives is less than 100%. Physician noncompliance with a patient's directive should not be immediately condemned as a violation of the patient's rights. Rather, the specific reasons for noncompliance should be carefully evaluated and addressed.

Although instruction directives were the most frequently used type of directive, those comprising proxy and instruction components were preferred. These mixed directives have the benefit of documenting patients' preferences regarding particular treatments while providing flexibility in the application of their preferences in clinical situations. It would also be important to know which type of directive patients prefer and which type leads to optimum patient care. If this is not in conflict with physicians' preferences we recommend greater use of mixed directives.

Over 90% of the physicians in our study agreed that an opportunity to complete an advance directive should be offered to terminally or chronically ill patients. Only 40% agreed that such an opportunity should be offered to all people admitted electively to hospital, and only 33% felt that it should be offered to patients admitted through the emergency department. Our data suggest that the patient self-determination provisions of the US Omnibus Budget Reconciliation Act, which require hospitals receiving Medicare or Medicaid reimbursement to inform all patients at the time of admission about their right to

Table 3: Attitudes of family physicians toward which strategies might encourage physicians to offer advance directives to their patients

	Effect of strategy; % of physicians		
Strategy	Encourage	Discourage	No effect
Education of the public about advance directives (n = 634)	92	1	8
Professional education of physicians about advance directives (n = 631)	90	1	9
Provincial legislation protecting a physician from possible legal consequences when following an advance directive (n = 637)	89	1	11
Provincial legislation supporting the use of advance directives (n = 636)	80	4	17
Hospital policy supporting the use of advance directives (n = 634)	79	2	20
Reimbursement for time spent with patients discussing advance directives (n = 634)	73	1	26
Hospital policy requiring that all patients routinely be offered the opportunity to complete an advance directive at the time of admission (n = 629)	64	11	25

complete a directive,[3] would meet with limited support from physicians in Canada.

The physicians in our study reported that the most effective strategies to increase the use of advance directives would be public and professional education programs. This finding may explain the apparent discrepancy between widespread legislation on directives and the low rate of use of directives. As with laws regarding routine inquiry and required request for organ donation[22] legislation alone on advance directives may not be sufficient to change physician behaviour. Education of the public and health care professionals is also required.

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